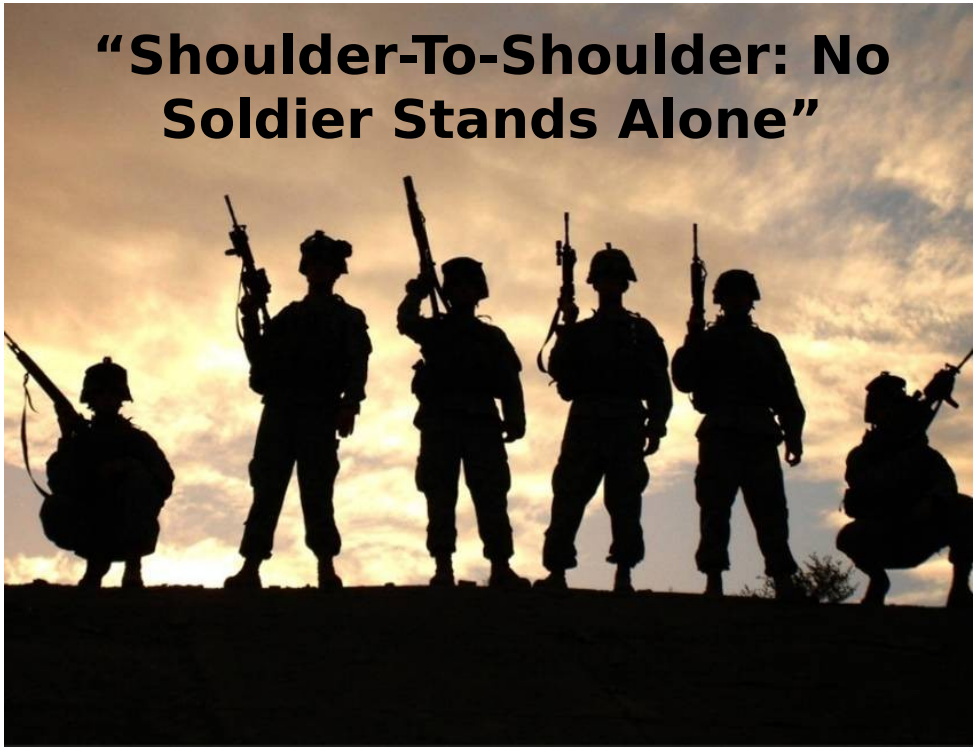
Army Suicide Prevention Program



Intervention Training Scenarios

Scenario #1 – Pre-deployment

Supporting Soldiers, Families & Civilians – Active, Guard, Reserve and Retired

The Soldier is an eighteen year old, active duty PVT (E2) whose unit will deploy to Iraq by the end of next month. This is his/her first deployment. He/she has heard many horrifying war stories from veterans who have deployed to Iraq. He/she suddenly feels quite uncomfortable with thought of deploying to Iraq. Every day he/she is becoming more and more anxious about this deployment. He/she is feeling quite powerless and overwhelmed. He/she has heard about several ways to avoid deployment. Frequently, he/she has been told that, to avoid being deployed, make a suicide gesture. As everyday passes, he/she finds him-herself thinking more and more about this COA.

The Soldier is talking to the First Sergeant about these thoughts.

What the First Sergeant does not know:

1. Your drinking has increased.
2. You are having panic attacks.
3. You are very fearful about getting killed in Iraq.

During your discussion, he/she tells the First Sgt.: “I can’t go on this deployment. I will do whatever it takes not to deploy.”

STRATEGIC QUESTIONS:

1. How could you have prepared your troops such that they do not experience excessive anxiety about deploying?
2. What resources are available to you to help prepare your unit?
3. What conditions would have to exist for YOU to seek services through the Community Mental Health Service. Do those conditions exist for your Soldiers?
4. How do you encourage Soldiers to appropriately seek mental health services, and how do you reduce any stigma regarding the use of such services?
5. You have been told your suicide rate is unacceptable. How do you go about reducing suicides in your unit?

STRATEGIC QUESTIONS and ANSWERS:

1. **How could you have prepared your troops such that they do not experience excessive anxiety about deploying?** *(use BATTLEMIND, create an environment that fosters help-seeking; eliminate policies and procedures which inadvertently punish soldiers for seeking assistance; assume responsibility for the mental health of your Soldiers; monitor Soldier access to needed services).*
2. **What resources are available to you to help prepare your unit?** (*Community Mental Health Service, Brigade mental health assets, medics, your chain-of-command; combat stress control; chaplains, your NCO's and junior officers).*
3. **What conditions would have to exist for YOU to seek services through the Community Mental Health Service. Do those conditions exist for your Soldiers?** *(For discussion).*
4. **How do you encourage Soldiers to appropriately seek mental health services, and how do you reduce any stigma regarding the use of such services?** (*counseling from the top down; education regarding mental health services; creating realistic attitudes about services; creating a supportive atmosphere in which Soldiers know they can express their problems and seek help without negative consequences).*
5. **You have been told your suicide rate is unacceptable. How do you go about reducing suicides in your unit?** (*know your Soldiers and have squad and platoon leaders know their Soldiers; solicit feedback from your Soldiers regarding their stressors; create a supportive environment where Soldiers feel comfortable talking with their leaders about the problems they are experiencing; training regarding the identification of individuals who may be at risk; consult with your mental health resources; emphasis on the buddy system; early intervention*).

TACTICAL QUESTIONS:

1. What should you do once the Soldier states he is willing to do anything to avoid deployment?
2. If you suspect the Soldier is malingering, what should you do?
3. Why should you not just confront the Soldier by telling him his threats are bogus?
4. What risk factors has this Soldier demonstrated (even though not necessarily known by the chain-of-command)?
5. What types of “suicide precautions” should you have in place for suicidal Soldiers who are not hospitalized?

TACTICAL QUESTIONS and ANSWERS:

1. **What should you do once the Soldier states he is willing to do anything to avoid deployment? (***Ask him if he is considering suicide as a possible alternative. If he says "No", do not assume he is answering honestly. Probe more deeply; ask more questions regarding his possible intent and plan. If the Soldier says "Yes", remain calm. Care for the Soldier by removing any means to harm him. Escort the Soldier to the nearest behavioral health provider or chaplain. Do not leave the Soldier alone.)*
2. **If you suspect the Soldier is malingering, what should you do? (***Regard it as a true incident of suicidal behavior. Let the mental health providers determine the best way to manage this Soldier. Inform your chain-of-command.)*
3. **Why should you not just confront the Soldier by telling him his threats are bogus?** *(Such confrontation violates all the principles of caring for a person with suicidal thought. You might actually drive the person into making a gesture or actually committing suicide. You are punishing the Soldier for expressing his thoughts and feelings and, if he ever does become truly suicidal, he may not express his intent the next time.)*
4. **What risk factors has this Soldier demonstrated (even though not necessarily known by the chain-of-command)?** (*Increased anxiety increased drinking, panic attacks, increased fear; irrational thinking and impaired problem-solving abilities.)*
5. **What types of "suicide precautions" should you have in place for suicidal Soldiers who are not hospitalized?** *(removal of the means to kill him/herself; unit watch; restriction to base; genuine care and concern from the chain-of-command).*

OPERATIONAL QUESTIONS:

1. How does one distinguish between malingerers and those Soldiers with bona fide mental health problems?
2. After speaking with this Soldier, he refuses to go to the Community Mental Health Service, the hospital, or the Chaplain's office. What should you do next?
3. This soldier, who lives off-post, fails to report for the morning formation. What should be done?
4. This is the third or fourth time this Soldier has gone AWOL. Each time he/she returned a few days later. The current sequence of events seems to be falling in line with his/her typical way of reacting to pressure. How should you, as this Soldier's leader, respond?
5. After he/she fails to report for morning formation and fails to respond to telephone calls, you go to the Soldier's house only to find him/her drunk and in his/her bed. During your conversation with the Soldier, he/she states that getting drunk is the only way he/she can avoid the "panic attacks". What would be your best course of action?

OPERATIONAL QUESTIONS and ANSWERS:

1. **How does one distinguish between malingerers and those Soldiers with bona fide mental health problems?** (*It is not possible to predict completed suicide at the individual level. One can only identify individuals who are at risk. Never assume that someone is malingering, even if their threats appear bogus.)*
2. **After speaking with this Soldier, he refuses to go to the Community Mental Health Service, the hospital, or the Chaplain's office. What should you do next?** *(Remain calm; explore the Soldier's fear of seeing a mental health professional; if he still refuses, you, you and another unit member, and/or military police must escort the Soldier to the nearest mental health care provider, whether that is a brigade asset, a Community Mental Health Service, or the hospital emergency room; do not leave the Soldier alone.)*
3. **This soldier, who lives off-post, fails to report for the morning formation. What should be done?** *(Make no assumptions. Try to telephone the Soldier. If the Soldier is married, try to contact his/her spouse. Talk with others to see if the Soldier discussed his/her plans with them If unable to reach the Soldier and/or his/her spouse telephonically, go to his/her house Notify your chain-of-command. Without disturbing the scene, look for other signs of possible intent: Is his/her automobile there? Are electrical appliances turned on? Discuss with your chain-of-command the necessity to contact civil authorities.)*
4. **This is the third or fourth time this Soldier has gone AWOL. Each time he/she returned a few days later. The current sequence of events seems to be falling in line with his/her typical way of reacting to pressure. How should you, as this Soldier's leader, respond**? (*Even though the Soldier has a history of acting in a similar fashion, one cannot make assumptions. One must respond to this situation as if it were a true suicidal emergency. It is better to be safe than to be sorry. Also, people will frequently make several "gestures" before they finally kill themselves. This Soldier feels he/she has a problem for which there is no solution, and his/her repeated "gestures" are probably his/her best way to communicate their desperation. As a leader, your first step must be to ensure the Soldier's safety. After that, you can assist them in formulating better solutions to their problems.)*
5. **After he/she fails to report for morning formation and fails to respond to telephone calls, you go to the Soldier's house only to find him/her drunk and in his/her bed. During your conversation with the Soldier, he/she states that getting drunk is the only way he/she can avoid the "panic attacks". What would be your best course of action?** *(While it would be easy to dismiss the Soldier's complaints as "excuses", one must leave diagnosis for the professionals. Since the Soldier is obviously intoxicated, you should report to your chain-of-command and **escort** the Soldier to the emergency room.)*

Scenario #2 – Warrior in Transition

Supporting Soldiers, Families & Civilians – Active, Guard, Reserve and Retired

SFC Rodriguez was a 39 year old, married, Hispanic male, who deployed to Iraq in 2006. Since his return in 2007, he has been in constant trouble with his unit. However, his unit has been generally very tolerant of his behavior. He was perceived by the command and fellow Soldiers as a hero. While on patrol in Iraq, SFC Rodriguez stopped a suicide bomber from entering his unit's area of operation. He spotted an intruder running towards his patrol. He yelled "Halt!" at the intruder; however, the person kept running in his direction. When he realized the individual was not going to stop, he opened fire, killing the intruder. The insurgent fell to the ground, setting off an IED. SFC Rodriguez was hit by shrapnel and rendered unconscious. At the time, he was diagnosed with mild traumatic brain injury. He received an ARCOM with valor and was credited with saving the lives of many fellow soldiers.

Since his return from IRAQ, SFC Rodriguez has begun to abuse alcohol. His drinking has had a negative effect on his marriage, and he has twice been referred to the Family Advocacy Program for spouse abuse. During one week-end drinking binge, he was involved in a motor vehicle accident which caused some minor injuries. He has been referred to the Behavioral Health and the Drug and Alcohol treatment programs, where he was diagnosed with alcohol dependence and depression. Given his diagnosis he has been provided with medications to improve his mood. Because of his continued nightmares, sleep problems, irritability, and frequent flashbacks to the IED event, he was finally diagnosed with posttraumatic stress disorder. In the Fall of 2007, he was referred to the Warrior Transition Unit for treatment and monitoring. He is to be medically discharged from the Army.

Shortly after being assigned to the Warrior Transition Unit, SFC Rodriguez got into another argument with his wife, accusing her of infidelity. During that argument, he threatened to kill himself. At this point, his wife became very concerned and decided to seek the help of a neighbor. When his wife returned, SFC Rodriguez was sitting on the bed holding his pistol. Mrs. Rodriguez called the MP's and the WTU caseworker, who persuaded SFC Rodriguez to give them his weapon. He was eventually seen by Behavioral Health in the hospital emergency room.

STRATEGIC QUESTIONS:

1. Is the present system of screening Soldiers upon their return from theater adequate? Why or why not?
2. What can be done within the Army to detect troubled Soldiers earlier, since early intervention works best by preventing a downward spiraling cycle of negative behaviors?
3. There are those who say that suicide prevention programs are a waste of money since suicide occurs so infrequently, since it is virtually impossible to predict actual suicide, and since there are larger issues to address. These same people feel that the suicide prevention program is largely a public relations response to a series of sensitive issues, such as the conditions at Walter Reed, the lack of adequate armor in theater, the return of thousands of severely injured Soldiers, etc. Do you feel suicide is an important issue to be addressing? Why or why not?
4. Has the Army's decision to take in a lager proportion of Category IV's affected the incidence of suicide? If so, how?
5. Even though it might increase challenges to recruiting goals, do you think a pre-enlistment screening for psychological stamina and mental health should be implemented? Why or why not?

STRATEGIC QUESTIONS and ANSWERS:

1. **Is the present system of screening Soldiers upon their return from theater adequate? Why or why not? (***any self-report is dependent upon the willingness of the Soldier to admit to problems; a Command climate free of stigma increases the effectiveness of the screening program).*
2. **What can be done within the Army to detect troubled Soldiers earlier, since early intervention works best by preventing a downward spiraling cycle of negative behaviors?** *(There is no single correct answer.)*
3. **There are those who say that suicide prevention programs are a waste of money since suicide occurs so infrequently, since it is virtually impossible to predict actual suicide, and since there are larger issues to address. These same people feel that the suicide prevention program is largely a public relations response to a series of sensitive issues, such as the conditions at Walter Reed, the lack of adequate armor in theater, the return of thousands of severely injured Soldiers, etc. Do you feel suicide is an important issue to be addressing? Why or why not?** *(No single correct answer.)*
4. **Has the Army's decision to take in a lager proportion of Category IV's affected the incidence of suicide? If so, how?** *(It has been demonstrated that mental health is correlated to a significant degree with intelligence. Those individuals with low scores frequently bring mental health problems with them when they enlist.)*
5. **Even though it might increase challenges to recruiting goals, do you think a pre-enlistment screening for psychological stamina and mental health should be implemented? Why or why not? (***No single correct answer.)*

TACTICAL QUESTIONS:

1. SFC Rodriguez left a trail of indications that he was having significant problems. List the various warning signs displayed by SFC Rodriguez in this scenario.
2. At what point in time could SFC Rodriguez have been helped most effectively?
3. Whose responsibility was it to identify SFC Rodriguez as being at risk for suicide?
4. SFC Rodriguez has now been successfully treated and has been returned to duty. What steps can you take to help him reintegrate into the unit and reassume his former position?
5. As a leader, would you have handled the situation differently had the soldier been a PFC with only one year of service? Why or why not?

TACTICAL QUESTIONS and ANSWERS:

1. **SFC Rodriguez left a trail of indications that he was having significant problems. List the various warning signs displayed by SFC Rodriguez in this scenario.** *(mild traumatic brain injury with loss of consciousness; alcohol abuse/dependence resulting in a motor vehicle accident; behaviors leading to referrals to the Family Advocacy Program, Behavioral Health, and the Substance Abuse Treatment Program; depression requiring medications; reports of continued nightmares and other sleep problems; his reports of frequent flashbacks; marital problems)*

2. **At what point in time could SFC Rodriguez have been helped most effectively?** *(At the first sign of behavioral/emotional problems)*

3. **Whose responsibility was it to identify SFC Rodriguez as being at risk for suicide?** *(everyone's)*

4. **SFC Rodriguez has now been successfully treated and has been returned to duty. What steps can you take to help him reintegrate into the unit and reassume his former position?***(discussion, there is no single right answer.)*

5. **As a leader, would you have handled the situation differently had the soldier been a PFC with only one year of service? Why or why not?** *(the answer should be no; one cannot make judgments about or put a value on human lives; all Soldiers should be managed fairly and humanely).*

OPERATIONAL QUESTIONS:

1. Describe how the ACE intervention model was applied in this case.
2. After seeing a mental health professional, SFC Rodriguez is admitted to the hospital. What should be your course of action?
3. SFC Rodriguez has been released from the hospital and returned to the WTU, where he is being processed for a medical discharge. Does this end your responsibility to this Soldier?
4. As SFC Rodriguez's first-line supervisor, what if anything do you do for *Mrs*. Rodriguez?
5. After one-year on TDRL, SFC Rodriguez has successfully dealt with his problems and has been pronounced fit to return to duty. In fact, he is being reassigned back to your unit. How do you assist SFC Rodriguez in reintegrating back into the unit?

OPERATIONAL QUESTIONS and ANSWERS:

1. **Describe how the ACE intervention model was applied in this case.** *(since the Soldier is obviously suicidal, immediate action was taken; caring was demonstrated verbally and by removing the weapon; the Soldier was escorted to the emergency room where he could get assistance)*
2. **After seeing a mental health professional, SFC Rodriguez is admitted to the hospital. What should be your course of action?** *(Maintain unit contact with the Soldier; express genuine sympathy; reward the Soldier verbally for being wise enough to seek assistance; assure the Soldier that he will be welcome once he returns to the unit; ask if there is anything you can help him with while he is in the hospital.)*
3. **SFC Rodriguez has been released from the hospital and returned to the WTU, where he is being processed for a medical discharge. Does this end your responsibility to this Soldier?** *(legally, yes. Morally and ethically there is less agreement. This Soldier has served your Army well for many years. To break off all contact and, in effect, ostracize him for having negative feelings will probably generate some degree of resentment on his part. Demonstrate to SFC Rodriguez that his contributions are remembered and valued. Maintain contact with SFC Rodriguez until, and perhaps even after, his discharge. If possible, assist him in his transition to civilian life. It is remarkable what an effect small kindnesses, such as sending a card a couple of times per year, can have.).*
4. **As SFC Rodriguez's first-line supervisor, what if anything do you do for *Mrs*. Rodriguez?** *(Mrs. Rodriguez has been an important part of the Army for a long time, and she deserves some assistance. Talk with her regarding any problems she is having and advise her of resources available to her both on-base and in the civilian community. Assure her that you are available if needed. The Golden Rule applies in many situations).*
5. **After one-year on TDRL, SFC Rodriguez has successfully dealt with his problems and has been pronounced fit to return to duty. In fact, he is being reassigned back to your unit. How do you assist SFC Rodriguez in reintegrating back into the unit?** *(First, assure SFC Rodriguez of your continued support. Reward him for his successful rehabilitation. Whenever the chance arises, demonstrate your confidence in SFC Rodriguez' abilities and judgment. Do not feel you must handle him gently; allow him to be the healthy adult he indeed is. It is very likely that, because of his experiences, SFC Rodriguez will come back a stronger and healthier person than before. It is likely that, because of his experiences, he will be a more understanding and compassionate leader.)*

Scenario #3 – Deployed Female

You are a twenty four year old, active duty Specialist. You are three months into your first deployment to theater. Your husband of three years sends you a text message requesting a divorce. He ends the message with, "…I am sorry…I didn't expect to fall in love with someone else."

You are talking to a fellow NCO about this situation.

She does not know:

1. Your husband has a history of being unfaithful.
2. Your husband previously requested a divorce. In response, you attempted suicide.

You composed a text message to your husband stating that you will die if he divorces you.

You are now having thoughts of killing yourself using your rifle.

In talking with your fellow NCO you state, "My husband wants to divorce me; I can't stand being here; If I were home, I could change his mind."

STRATEGIC QUESTIONS:

1. How does one manage relationship problems that have the potential of impacting mission accomplishment?
2. What support personnel/offices has Command made available to this Soldier and to other Soldiers?
3. In some cases, one suicide has reportedly set off a “cluster” of other suicides. What mechanisms would you put in place to prevent a cluster of suicides/suicide attempts?
4. How will you determine the success or failure of suicide prevention measures you have implemented?
5. The suicide rate of your unit has consistently been higher than other units at the same echelon, even though you have implemented a suicide prevention program. What steps can you take to change this situation?

STRATEGIC QUESTIONS and ANSWERS:

1. **How does one manage relationship problems that have the potential of impacting mission accomplishment?** Is it Command's job to concern themselves with such problems? Within the command, who is best suited to address such problems? *(Yes, anything that impacts unit performance is a concern of Commanders. The NCO staff appears best suited to identify and monitor such problems, making appropriate referrals when necessary.)*
2. **What support personnel/offices has Command made available to this Soldier and to other Soldiers?** *(Community Mental Health; Combat Stress Team; Brigade Psychologist's office; her chain-of-command; chaplains, JAG; possibly others).*
3. **In some cases, one suicide has reportedly set off a "cluster" of other suicides. What mechanisms would you put in place to prevent a cluster of suicides/suicide attempts?** *(the most effective mechanism is a trained and sensitive chain-of-command that effectively and efficiently communicates information upwards and downwards; the entire chain-of-command must be genuinely caring and supportive, even if individuals feel they are being manipulated; one could ask chaplains and/or mental health experts to come into the organization and present frank information regarding suicide).*
4. **How will you determine the success or failure of suicide prevention measures you have implemented?** *(Command climate surveys; Battlemind survey; Behavioral Health Needs Assessment survey).*
5. **The suicide rate of your unit has consistently been higher than other units at the same echelon, even though you have implemented a suicide prevention program. What steps can you take to change this situation?** *(consult with your chain-of-command; consult with other leaders at the same echelon to determine what differences exist between your and their units; consult with behavioral health specialists; survey your unit regarding individual stressors and stressors that affect the entire unit; ensure that your chain of command is knowledgeable about, and sensitive to, behaviors which can signal potential suicidal thought).*

TACTICAL QUESTIONS:

1. As a unit Commander, do you want to take this Soldier into combat? Why or why not?
2. You refer the Soldier for a mental status evaluation. The provider responds that the SPC is not currently at a high-risk for suicide. However, the provider also recommends unit watch and follow-up treatment at the mental health center. What should your course of action be?
3. What are the pros and cons of the various administrative actions available to you regarding this Soldier, such as chapter action versus limited duty versus medivac/hospitalization versus return to full duty?
4. Many of your Soldiers could have marital problems. Many of them will handle the situation well. Others may become suicidal. Still others may not talk about it. We call the difference between those who handle such stress well and those who do not “resilience”. Are there things you can do to build resilience within your unit?
5. At what point should Command begin to think in terms of a chapter action or medical board for suicidal Soldiers?

Scenario #3 – Deployed Female

Supporting Soldiers, Families & Civilians – Active, Guard, Reserve and Retired

TACTICAL QUESTIONS and ANSWERS:

1. **As a unit Commander, do you want to take this Soldier into combat? Why or why not? (***There is no correct answer. For discussion)*
2. **You refer the Soldier for a mental status evaluation. The provider responds that the SPC is not currently at a high-risk for suicide. However, the provider also recommends unit watch and follow-up treatment at the mental health center. What should your course of action be? (***Discuss the Soldier's condition telephonically or face-to-face with the provider so that you are clear regarding the Soldier's mental health status and so you and the provider can assist each other in helping the Soldier. Resolve, to your satisfaction, the seemingly contradictory recommendations of the mental health provider [i.e. Not at a high risk for suicide but, nevertheless, placed on unit watch.]).*
3. **What are the pros and cons of the various administrative actions available to you regarding this Soldier, such as chapter action versus limited duty versus medivac/hospitalization versus return to full duty?** *(Ideally, using the various resources available to you, you will ultimately be able to return this Soldier to full duty. Many mental health providers are reluctant to hospitalize Soldiers, because few such Soldiers return to make the contributions they are capable of and, thus, are frequently medically boarded out of the Army. Such an action causes manpower shortages within the unit and probably leads to further, more long-term psychological problems for the Soldier following discharge. The best place for treatment of the suicidal Soldier is within his/her unit. However, such "within-unit treatment" makes many Commanders uncomfortable. Commanders also frequently feel that such "within-unit treatment" saps the unit's strength. If at all possible, return the Soldier to limited duty as quickly as possible, in conjunction with mental health provider recommendations, followed by a return to full duty once the crisis is resolved. Such a course of action meets Army treatment conditions of immediacy, proximity, and brevity. Unfortunately, many Commanders are quick to chapter who cause problems, and many mental health care providers are eager to comply with the Commanders' decisions. In an era where enlistment standards have been lowers and where the Army is having trouble filling its ranks, such a "quick draw" on chapter actions is not without negative consequences, for both the Army and the Soldier in question.)*
4. **Many of your Soldiers could have marital problems. Many of them will handle the situation well. Others may become suicidal. Still others may not talk about it. We call the difference between those who handle such stress well and those who do not "resilience". Are there things you can do to build resilience within your unit? (***Yes. Use BATTLEMIND and create an atmosphere wherein individuals feel free to talk about their problems without fear of reprisal or ridicule.)*
5. **At what point should Command begin to think in terms of a chapter action or medical board for suicidal Soldiers?** *(When it is determined that the Soldier's problems are of sufficient severity and chronicity that the Soldier's ability to perform his/her job is significantly impaired; when it is determined that the Soldier's behaviors constitute a realistic threat to others; and/or when it can be determined with a reasonable degree of certainty that the Soldier cannot be rehabilitated.).*

OPERATIONAL QUESTIONS:

1. What is the first thing the fellow NCO in this scenario should do?
2. The Soldier denies feeling suicidal. What should her fellow NCO do now?
3. The fellow NCO finds out that the Soldier is entertaining thoughts of suicide. What should she do now?
4. What factors place this Soldier at a higher than normal risk for suicide?
5. What factors serve to protect this Soldier?

OPERATIONAL QUESTIONS and ANSWERS:

1. **What is the first thing the fellow NCO in this scenario should do?** *(express concern and ask if the Soldier is feeling suicidal).*

2. **The Soldier denies feeling suicidal. What should her fellow NCO do now?** *(keep exploring to make sure the Soldier is not denying her feelings or is too embarrassed to discuss her situation).*

3. **The fellow NCO finds out that the Soldier is entertaining thoughts of suicide. What should she do now?** *(express caring and concern and take away the Soldier's rifle; then she should escort the Soldier to the appropriate mental health facility and/or someone higher in her chain-of-command; the Soldier should never be left alone).*

4. **What factors place this Soldier at a higher than normal risk for suicide?** *(a previous attempt; a failing relationship; feelings of powerlessness).*

5. **What factors serve to protect this Soldier?** *(she is not keeping her problems secret. In fact, she appears to be asking for help).*

Scenario #4 – Post-Deployment

John is a thirty year old Specialist in the National Guard. He has just returned from his first deployment in Afghanistan. During this deployment, he received an article 15 for insubordination. John just discovered that his girlfriend has been unfaithful and no longer wants to see him. He was very embarrassed by the article 15, and now he is feeling quite sad about losing his girlfriend.

He is talking to a fellow Soldier.

What the fellow Soldier does not know:

1. John is feeling sad and taking medication to help him sleep.
2. Until the article 15, John wanted to make the Army his career.
3. John has been diagnosed with depression in the past.
4. He is feeling like he did three years ago, when he tried to kill himself.
5. He is considering killing himself by overdosing on sleeping pills.

Sometime during the conversation John says, “I can’t take it any more.”

STRATEGIC QUESTIONS:

1. Do Guardspersons and Reservists have any special needs that must be considered as part of your suicide prevention program?
2. As a Commander, would you permit your unit to be used as subjects in research into suicide prevention? Why or why not?
3. Are increasing suicide rates a part of the “unraveling” of the Army spoken of by Gen. (Ret.) Barry McCaffrey? Why or why not?
4. Do you believe that suicide prevention is not as important in an organization based on a Warrior ethos? Why or why not?
5. As a leader, do you feel you have a moral, ethical, or legal obligation to your Soldiers and, by extension, to the safety of your Soldiers? Why or why not?

STRATEGIC QUESTIONS and ANSWERS:

1. **Do Guardspersons and Reservists have any special needs that must be considered as part of your suicide prevention program?** *(necessity to readjust from civilian to military and back to civilian; financial pressures are different)*

2. **As a Commander, would you permit your unit to be used as subjects in research into suicide prevention? Why or why not? (***for discussion; much more research is needed to truly understand suicide and the prevention of suicide.)*

3. **Are increasing suicide rates a part of the "unraveling" of the Army spoken of by Gen. (Ret.) Barry McCaffrey? Why or why not?** *(Many people see increasing suicide rates as but one indication of systemic distress; other indicators include the increasing loss of NCO's and company grade officers; the need to significantly increase enlistment incentives, etc.)*

4. **Do you believe that suicide prevention is not as important in an organization based on a Warrior ethos? Why or why not?** *(preventing suicidal behavior is part of the warrior ethos – never leave a fallen comrade; some service members may not have actually embraced the warrior ethos).*

5. **As a leader, do you feel you have a moral, ethical, or legal obligation to your Soldiers and, by extension, to the safety of your Soldiers? Why or why not?** *(people are more than expendable items or "human capital", they are human beings with the same desire to live as you; you certainly have a moral and ethical obligation to your Soldiers, even in spite of the Ferres doctrine; an argument for a legal obligation could be made in cases involving dereliction of duty.)*

TACTICAL QUESTIONS:

1. You get the feeling that the Soldier is using his circumstances to obtain some special treatment from Command. What should you do?
2. John explains that he does not want to go to behavioral health or the chaplain, because his peers would view him as weak. What should you do?
3. How do you determine if John is having thoughts of suicide?
4. John confides to his friend that he is indeed feeling depressed and suicidal and that he is considering taking an overdose. What should his friend do next?
5. After removing the pills, what should the friend and chain-of-command do next?

TACTICAL QUESTIONS and ANSWERS:

1. **You get the feeling that the Soldier is using his circumstances to obtain some special treatment from Command. What should you do?** *(do nothing; refer the Soldier to mental health and wait for a mental health provider to make a diagnosis; do not be judgmental).*

2. **John explains that he does not want to go to behavioral health or the chaplain, because his peers would view him as weak. What should you do?** *(Explain that it takes courage to deal with one's problems, and that you are impressed that he had the strength to discuss his problems with you. Next, insist that John see a behavioral health specialist or a chaplain. If John continues to refuse, have him escorted to the emergency room.)*

3. **How do you determine if John is having thoughts of suicide?** *(Ask him directly. Ask him if he has an idea how he would do it. Ask if he has medications available to him. Ask if he has ever tried suicide before.)*

4. **John confides to his friend that he is indeed feeling depressed and suicidal and that he is considering taking an overdose. What should his friend do next?** *(Without leaving John alone, he should notify the chain-of-command, who in turn should demonstrate caring by confiscating the medicine bottles.)*

5. **After removing the pills, what should the friend and chain-of-command do next?** *(John should be escorted to the Community Mental Health Service or, after hours, the emergency room.)*

OPERATIONAL QUESTIONS:

1. What are the two major factors that place this Specialist at a higher than normal risk for suicide?
2. What should be your first response to his statement, “I can’t take it any more”?
3. While talking to this Soldier, you start to feel very uncomfortable and doubt your abilities to be very helpful. What would be your best course of action?
4. This Soldier agrees to speak with you only if your promise not to tell anyone else. What should you do?
5. Do you think John is actually suicidal? Why or why not?

OPERATIONAL QUESTIONS and ANSWERS:

1. **What are the two major factors that place this Specialist at a higher than normal risk for suicide?** *(previous attempt; distressing life events).*

2. **What should be your first response to his statement, "I can't take it any more"?** *(Ask if he has been having thoughts about suicide.)*

3. **While talking to this Soldier, you start to feel very uncomfortable and doubt your abilities to be very helpful. What would be your best course of action?** *(Without leaving the Soldier alone, notify your chain-of-command.)*

4. **This Soldier agrees to speak with you only if your promise not to tell anyone else. What should you do?** *(Explain that you cannot make such a promise. If he refuses to continue, escort him to your supervisor or to a mental health professional).*

5. **Do you think John is actually suicidal? Why or why not?** *(There can be a variety of responses. However, it is important to note that the proper people to make this determination are mental health providers.)*

Scenario #5 – Pre-deployment

You are the First Sergeant of a unit. A twenty year-old active duty PVT (E2) is preparing for her first deployment to Iraq. She recently received an Article 15 for being AWOL. She tells you that her husband has "maxed out" the credit cards, and that the bank is threatening to start foreclosure proceedings if she does not make an immediate house payment. She is feeling quite powerless and overwhelmed.

What you do not know:

1. The PVT has been fighting daily with her husband about the finances.
2. Her drinking has increased.
3. She just increased the amount of death benefits on her insurance.
4. She has been thinking about volunteering for any dangerous mission to end her life.

During your discussion with her, she tells you: "I love my husband, and I have a plan to make sure he is taken care of when I'm gone."

STRATEGIC QUESTIONS:

1. Do you think that current suicide prevention strategies are presented to all concerned constituencies (i.e. Guard, Reserves)?
2. Given all the required training and classes Soldiers must receive before being deployed, do you think the suicide prevention message gets lost in the "noise?" Why or why not?
3. If you think the message is getting lost, how do you improve the "signal to noise ratio"?
4. What factors do you think contribute to the increase in the Army's suicide rate when compared to that of other services?
5. If you were the Army Surgeon General, what kind of suicide prevention measures would you put in place other than educational classes and the "buddy system"?

STRATEGIC QUESTIONS and ANSWERS:

1. **Do you think that current suicide prevention strategies are presented to all concerned constituencies (i.e. Guard, Reserves)? Why or why not?** *(there is no single correct answer; for discussion).*

2. **Given all the required training and classes Soldiers must receive before being deployed, do you think the suicide prevention message gets lost in the "noise?" Why or why not?** *(there is no single correct answer; for discussion).*

3. ***If you think the message is getting lost, how do you improve the "signal to noise ratio"?*** *(there is no single correct answer; for discussion).*

4. **What factors do you think contribute to the increase in the Army's suicide rate when compared to that of other services?** *(numerous factors may be identified such as lowered recruiting standards; optemps, extension of tours, inadequate time for rest and recovery; prior unavailability of resources to assist Soldiers in transitioning back to a garrison mentality and then back to a theater mentality, etc.).*

5. **If you were the Army Surgeon General, what kind of suicide prevention measures would you put in place other than educational classes and the "buddy system"?** *(for discussion)*

TACTICAL QUESTIONS:

1. Do you have any suspicions that this PVT may be suicidal? If so, why?

2. How would you determine whether or not she is a danger to herself or others?

3. Your unit is due to deploy in two weeks. Do you want to take this Soldier with you? Why or why not?

4. After a few days of counseling at the Community Mental Health Service and consultations with JAG, Army Emergency Relief, and a credit management agency, the PVT announces that she is feeling much better and wishes to deploy with the unit. The mental health provider informs you, via your request for a mental status examination, that the Soldier is fit for duty. What do you do?

5. You decide that the PVT will deploy with you. Once you in theater, however, she volunteers for some very hazardous tasks. What do you make of this, and how do you respond?

TACTICAL QUESTIONS and ANSWERS:

1. **Do you have any suspicions that this PVT may be suicidal? If so, why?** *(her relative youth; perhaps some anxiety about deploying and leaving her family; recent nonjudicial punishment; financial distress, reference to potential non-being, i.e. death).*

2. How would you determine whether or not she is a danger to herself or others? ***(Ask**; if unsure, **escort** to mental health provider if necessary).*

3. **Your unit is due to deploy in two weeks. Do you want to take this Soldier with you? Why or why not?** *(With proper treatment, suicidal ideation can be rather fleeting in nature. Interventions addressing her financial status and alcohol consumption could produce positive results. Leaving her behind could be seen as rejection by her unit, causing her to feel weak, unwanted, and incompetent. On the other hand, deploying with her could also possibly result in overwhelming stress for her. This is a judgment call you will have to make. Be sure to consult with all those individuals who could help you make this decision).*

4. **After a few days of counseling at the Community Mental Health Service and consultations with JAG, Army Emergency Relief, and a credit management agency, the PVT announces that she is feeling much better and wishes to deploy with the unit. The mental health provider informs you, via your request for a mental status examination, that the Soldier is fit for duty. What do you do?** *(the best course of action would probably be to sit and talk with the Soldier about her feelings then and now; ask her how she knows she is ready to deploy; ask about her home situation and whether or not her worries about her husband might cause her distress once overseas; based upon your judgment, you will decide whether or not she deploys; it would seem wise to speak with the mental health provider to learn the reasoning behind his recommendation).*

5. **You decide that the PVT will deploy with you. Once you in theater, however, she volunteers for some very hazardous tasks. What do you make of this, and how do you respond?** *(again, it is essential to maintain good communication with the Soldier in order to determine the motivation for her volunteerism; if uncertain, request another consultation from a mental health provider)*

OPERATIONAL QUESTIONS:

1. When the private states she has a plan to make sure her husband is taken care of when I'm gone, what should your response be?
2. Why do you think it is important to ask a potentially suicidal individual about their substance use/abuse?
3. What facts about this case suggest that the private is indeed suicidal?
4. Are there any factors in this scenario which may serve to reduce suicide potential?
5. The Soldier finally admits that she is experiencing significant marital distress. What importance do you attach to this fact?

OPERATIONAL QUESTIONS and ANSWERS:

1. **When the private states she has a plan to make sure her husband is taken care of when I'm gone, what should your response be?** *(You should ask her directly what she means by that statement. Is she merely stating a fact, or is communicating suicidal thoughts? She might be giving a clue, wanting someone to rescue her. You might begin by asking her what her plan is. If you have any questions, contact your chain-of-command.)*

2. **Why do you think it is important to ask a potentially suicidal individual about their substance use/abuse? (***Drinking or taking drugs may increase the person's impulsivity. Thus, they might commit suicide impulsively while intoxicated whereas they might not had they been sober. Also, an intoxicated Soldier would not be an appropriate referral to the Community Mental health Service. Rather, they should be escorted to the emergency room.)*

3. **What facts about this case suggest that the private is indeed suicidal?** *(The fact that the private has recently been involved in disciplinary actions. She has financial problems for which she sees no solution. She has been told she may lose her house to foreclosure. She is also experiencing the stress associated with deploying for the first time. At home she experiences marital discord. She has increased her alcohol intake. She is in the process of preparing for her absence by increasing the death benefits on her insurance, and she states she wants to volunteer for hazardous assignments so she will be killed.)*

4. **Are there any factors in this scenario which may serve to reduce suicide potential?** *(Yes, the Soldier is young and a female. Females make more suicidal "gestures" but these "gestures" are usually not as lethal as those made by males. There does not appear to be a history of suicide attempts. Furthermore, her wish to be killed on a hazardous mission seems to suggest that she is not imminently suicidal.)*

5. **The Soldier finally admits that she is experiencing significant marital distress. What importance do you attach to this fact?** *(Relationship problems are involved in a large percentage of suicides. It is therefore important to question potentially suicidal individuals regarding their marriages/relationships.)*

Scenario #6 – Deployed Captain

A 27 year-old, active duty Captain (O3) is in his third month of his second deployment. This deployment has brought back many painful memories from his first deployment. Up to this point in time, he has been able to cope with the memories. However, on a recent patrol, two guys in his unit were gunned down by insurgents. He failed to fire back at the enemy. Now that he is safely back in the rear area, he finds himself obsessed with this incident. He cannot understand why his men were killed but he is still alive.

He is talking about the firefight with his boss, who does not know:

1. He is struggling with recurrent, intrusive thoughts from his first deployment.
2. He failed to fire back at the enemy during the firefight.
3. He is feeling guilty about the deaths of his Soldiers.
4. He now has frequent thoughts about joining his dead comrades.

At some point in the conversation, he states “I should have died with my men.”

STRATEGIC QUESTIONS:

1. A lot of attention is given to the enlisted Soldier. Is equal attention given to the morale and welfare of junior officers? Why or why not?
2. With all this attention on suicide prevention, what prevents Soldiers from exploiting “the S word” to their advantage in order to shirk duties or obligations?
3. Where do you think behavioral health assets should be positioned?
4. Since many suicides occur off-post, how do you, as a Commander, monitor suicide risk factors among Soldiers who do not reside in the barracks?
5. Given the current OPTEMPS, what resources do you realistically have at your disposal to monitor the psychological status of your unit in order to prevent suicide?

STRATEGIC QUESTIONS and ANSWERS:

1. **A lot of attention is given to the enlisted Soldier. Is equal attention given to the morale and welfare of junior officers? Why or why not?** *(For discussion).*

2. **With all this attention on suicide prevention, what prevents Soldiers from exploiting "the S word" to their advantage in order to shirk duties or obligations?** *(The threat of suicide is one of a Soldier's best tools for "manipulating the system." For the less adapted Soldiers, there is nothing to stop such exploitation of medical services. If diagnosed as malingering, the SM could be subjected to a rather stiff penalty. However, malingering is difficult to diagnose. With Soldiers who fail to respond to any other motivation, UCMJ action is probably the best courses of action, with the understanding that such action might cause the SM to make some sort of gesture during which they might accidentally harm themselves. For better adapted Soldiers, unit cohesion, individual and group values, and recognition of the consequences of their behaviors will serve to avoid misuse of behavioral health resources).*

3. **Where do you think behavioral health assets should be positioned?** *(there may be a variety of responses; however, generally speaking, such assets should be deployed as close to the action as possible, not back in an office in the rear).*

4. **Since many suicides occur off-post, how do you, as a Commander, monitor suicide risk factors among Soldiers who do not reside in the barracks?** *(for discussion).*

5. **Given the current OPTEMPS, what resources do you realistically have at your disposal to monitor the psychological status of your unit in order to prevent suicide?** *(a well-trained, sensitive NCO Corps and junior officers, behavioral health assets, combat stress control; chaplains, Command climate surveys; Battlemind surveys; Behavioral Needs Assessment Survey).*

TACTICAL QUESTIONS:

1. Is this officer at a low, medium, or high risk for suicide?.
2. Do you think this officer's PTSD and survivor's guilt prevents him, in any way, of fully carrying out his duties? Why or why not?
3. Assuming that, following treatment, this Captain returns to duty and proves himself to be an effective leader, do you think this incident should negatively impact his OER? Why or why not?
4. In terms of maintaining his standing with his Soldiers, what do you think would be this Captain's best course of action?
5. Once an officer develops significant emotional problems, such as those demonstrated by this Captain, is he or she of any further use to the Army? Can an officer resume the position of authority he/she previously had? Why not just discharge all these people out of the service?

TACTICAL QUESTIONS and ANSWERS:

1. **Is this officer at a low, medium, or high risk for suicide?** *(Low; in spite of some survivor's guilt, posttraumatic stress disorder, and thoughts of death, there are no indications of imminent risk for suicide; however, this Captain should be encouraged to consult with a mental health specialist regarding his PTSD and survivor's guilt).*

2. **Do you think this officer's PTSD and survivor's guilt prevents him, in any way, of fully carrying out his duties? Why or why not?** *(the officer's failure to fire his weapon during the encounter may be an indication that his judgment and/or attention may be compromised; consider mental health treatment possibly coupled with some rest and restoration).*

3. **Assuming that, following treatment, this Captain returns to duty and proves himself to be an effective leader, do you think this incident should negatively impact his OER? Why or why not?** *(It is highly probably that this officer will be an asset to the Army. He should not be viewed as being "weak" or "sick" in any way. His PTSD and survivor's guilt are normal reactions to an abnormal situation. In fact, his experiences may make him a more understanding leader.)*

4. **In terms of maintaining his standing with his Soldiers, what do you think would be this Captain's best course of action?** *(There may be a variety of responses. However, honest, self-disclosure appears to be the most effective response. Such a response might even elicit similar feelings from other members of his unit. There is no problem in being viewed as human).*

5. **Once an officer develops significant emotional problems, such as those demonstrated by this Captain, is he or she of any further use to the Army? Can an officer resume the position of authority he/she previously had? Why not just discharge all these people out of the service?** *(These are decisions that must be made on a case-by-case basis; many people, upon resolution of their crisis, return to duty and prove to be highly effective Soldiers. One must also consider the effect any punishment or adverse action will have vis-à-vis stigma surrounding mental health services. One must also consider the Army's shortage of junior officers and the impending shortage in senior leadership. The feelings that this Captain is experiencing are normal human reactions to an abnormal situation. If the Captain can successfully work through his problems, should he not be given the benefit of the doubt? Should this Captain's career be ruined because he felt normal human emotions?).*

OPERATIONAL QUESTIONS:

1. What would be the best response to the Captain's statement, "I should have died with my men."?
2. How soon should the Captain be returned to his leadership position?
3. Do you think this Captain is imminently suicidal? Why or why not?
4. Does the fact that this Captain failed to return fire on the enemy after two of his Soldiers were gunned down have any bearing on your actions?
5. In talking with this officer, he states that he worries his own inattention and distractibility may place his soldiers' lives in jeopardy. He feels he is currently unfit to be leading Soldiers in battle. He also admits to frequent, intrusive thoughts regarding events that occurred during his first deployment? How do you respond?
6. Following another consultation with mental health, the PVT is diagnosed as having a bipolar disorder. The provider explains that, in such a disorder, rapid and substantial mood swings are likely. The provider also explains that the PVT is not responding to medications for this disorder. What course of action do you think best in such a situation?

OPERATIONAL QUESTIONS and ANSWERS:

1. **What would be the best response to the Captain's statement, "I should have died with my men**."? *(**Ask** further questions to clarify the Captain's intent. Is he expressing a real wish to be dead? Is he merely expressing his grief and survivor's guilt? Is there some other motivation for such a statement?)*
2. **How soon should the Captain be returned to his leadership position?** *(As quickly as possible).*
3. **Do you think this Captain is imminently suicidal? Why or why not?** *(For discussion)*
4. **Does the fact that this Captain failed to return fire on the enemy after two of his Soldiers were gunned down have any bearing on your actions?** *(While his "freezing up" may be a matter for discussion, we must distinguish that issue from the issue of suicide. We are interested in the Captain's safety and his ability to return to duty. This Captain is having a normal human reaction to an abnormal situation. It is likely that he is experiencing posttraumatic stress disorder and "survivor's guilt", both of which could contribute to suicidal thoughts or intent.)*
5. **In talking with this officer, he states that he worries his own inattention and distractibility may place his soldiers' lives in jeopardy. He feels he is currently unfit to be leading Soldiers in battle. He also admits to frequent, intrusive thoughts regarding events that occurred during his first deployment? How do you respond?** *(You should encourage the Captain to speak with a chaplain or mental health care provider. Has this Captain "fallen off his horse", and does he need to get back on and ride again? Is the Captain's concern that he may fail his men sufficient that he needs to be medivac'd out of theater? Will continuing to serve only make his PTSD worse? Is his career over? These are issues for which the Captain requires consultation.)*
6. **Following another consultation with mental health, the PVT is diagnosed as having a bipolar disorder. The provider explains that, in such a disorder, rapid and substantial mood swings are likely. The provider also explains that the PVT is not responding to medications for this disorder. What course of action do you think best in such a situation?** *(for the protection of the PVT and those around her, she should probably be "medivac'd" to Europe or CONUS for more intensive examination and treatment. If she does not respond to treatment, a medical board is probably necessary).*

Scenario #7 – Deployed Female SSG

Prior to her deployment, this 30 year old, National Guard SSG had a violent verbal argument with her husband. After 3 months in theater, she finds that she is still haunted by her memory of this argument. There is no relief from her husband; each time she calls home, her husband begins to argue again. During her most recent phone call, her husband stated, “The kids really miss you. You are a bad mother for leaving your babies like this. You are useless as a mother.” The SSG already feels powerless about her situation, and her husband’s last comments really hurt her.

She is talking to the Chaplain.

The Chaplain does not know:

1. She is feeling quite guilty about being separated from her two young children.
2. On several occasions, her husband has threatened to divorce her.
3. Since deploying, she has not slept or eaten well.
4. She has thought several times of killing herself using her own weapon.

At some point during the conversation, she states, “I am useless to my family…my children would be better off if I were dead.”

STRATEGIC QUESTIONS:

1. What is the role of Chaplains in cases of potential suicide?
2. It is a community standard that the least restrictive environment be used when treating people. As a result, individuals are not psychiatrically hospitalized involuntarily unless they are at an imminent risk to themselves and others. How should we as an organization define imminent risk?
3. At what point should a Chaplain or mental health provider reveal confidential information to others?
4. The Ferres doctrine states, in effect, that military leaders cannot be sued for actions which result in damages to a Soldier. If there was no Ferres Doctrine, how would you change the way you handle suicidal Soldiers?
5. To what lengths do you think Command should go to rehabilitate a formerly suicidal individual? At what point do you determine to “cut your losses” and get rid of the individual?

STRATEGIC QUESTIONS and ANSWERS:

1. **What is the role of Chaplains in cases of potential suicide? (***They can provide an alternative to mental health services, and there is less stigma about consulting with the Chaplain. Chaplains may be more adept at exploring a person's values and beliefs. Some individuals may feel more comfortable talking with a Chaplain. Some individuals may feel that they have greater confidentiality when speaking with a Chaplain.)*

2. **It is a community standard that the least restrictive environment be used when treating people. As a result, individuals are not psychiatrically hospitalized involuntarily unless they are at an imminent risk to themselves and others. How should we as an organization define imminent risk? (***Most federal and state courts have defined imminent risk as the probability that a person will harm him/herself or others within 24 hours.)*

3. **At what point should a Chaplain or mental health provider reveal confidential information to others?** *(Release of confidential information is permitted when another health care provider is assisting in the treatment of the individual. Confidentiality may also be broken when the individual is imminently suicidal. If imminently homicidal, the provider may notify the MP's and any specifically named target. For instance, it would be proper to alert SFC Jones that the SSG states that he will kill him tonight. It is not permissible to break confidentiality if the SM states something to the effect of, "I am going to kill people at random tonight. Confidentiality may also be broken in cases where the information obtained would significantly affect the unit's ability to perform its mission. Finally, confidentiality may be broken in cases where the provider is ordered by a court to provide specific information).*

4. **The Ferres doctrine states, in effect, that military leaders cannot be sued for actions which result in damages to a Soldier. If there was no Ferres Doctrine, how would you change the way you handle suicidal Soldiers?** *(for discussion).*

5. **To what lengths do you think Command should go to rehabilitate a formerly suicidal individual? At what point do you determine to "cut your losses" and get rid of the individual?** *(For discussion).*

TACTICAL QUESTIONS:

1. Besides talking with this person, what other action should you, as a Chaplain, take?
2. As a Chaplain and because you feel that the SSG is probably not able to fully perform her duties, you recommend that her Command consider a short period of rest and restoration. The Commander asks, “Why?” What information can you or should you release to the Commander?
3. When confronted with a case of potential suicide, what rules do you, as a Commander, use to decide what your best course of action is, e.g. referral to a Chaplain or mental health provider, versus possible UCMJ action, versus chapter action?
4. After referring this Soldier for a mental status examination, the examining provider recommends that the individual be placed on unit watch. As the unit Commander, you feel to do so would impair your ability to accomplish your mission, because the unit watch would tie up too many of your Soldiers. What do you do?
5. Instead of referring this Soldier for a mental status examination, you “strongly recommend” that she seek mental health consultation. A week later you learn that your unit is moving elsewhere in the theater. You call the mental health provider to find out whether or not this SSG can move with you. How do you respond when the mental health provider informs you that all contacts with the SSG were privileged and that, as a consequence, he/she cannot legally or ethically discuss the issue with you.

TACTICAL QUESTIONS and ANSWERS:

1. **Besides talking with this person, what other action should you, as a Chaplain, take?** *(Confiscate the SSG's weapon, explaining that you are doing this because you genuinely care about her).*

2. **As a Chaplain and because you feel that the SSG is probably not able to fully perform her duties, you recommend that her Command consider a short period of rest and restoration. The Commander asks, "Why?" What information can you or should you release to the Commander?** *(Hopefully you would have already obtained a release of information from the SSG so you can be frank with the Commander. However, since the SSG's condition can negatively effect unit performance you may discuss any information available to you about the SSG. You should release only that information which is pertinent to unit functioning).*

3. **When confronted with a case of potential suicide, what rules do you, as a Commander, use to decide what your best course of action is, e.g. referral to a Chaplain or mental health provider, versus possible UCMJ action, versus chapter action?** *(for discussion).*

4. **After referring this Soldier for a mental status examination, the examining provider recommends that the individual be placed on unit watch. As the unit Commander, you feel to do so would impair your ability to accomplish your mission, because the unit watch would tie up too many of your Soldiers. What do you do?** *(There are no right or wrong answers. For discussion.)*

5. **Instead of referring this Soldier for a mental status examination, you "strongly recommend" that she seek mental health consultation. A week later you learn that your unit is moving elsewhere in the theater. You call the mental health provider to find out whether or not this SSG can move with you. How do you respond when the mental health provider informs you that all contacts with the SSG were privileged and that, as a consequence, he/she cannot legally or ethically discuss the issue with you.** *(This is a tough issue. How does one balance confidentiality with a Commander's need to know? Breaking confidentiality can create a distrust of mental health providers among Soldiers. Failing to break confidentiality could impact the unit's performance. In an ideal world, the SSG would grant the provider provide to the provider a justification for the release of the information, such as evidence that such information is essential to mission accomplishment.)*

OPERATIONAL QUESTIONS:

1. What is the best way to deal with a suicidal Soldier who is not an imminent risk, that is a Soldier who is unlikely to harm him/herself or others within the next 24 hours?
2. How does one respond to this Soldier's statement that: "I am useless to my family…my children would be better off if I were dead".
3. You are attempting to demonstrate that you truly care about the SSG. You say, "I know its tough right now, but this crisis is going to pass, and you will eventually feel better. Let's talk some more about this tomorrow". Is there anything wrong with this approach?
4. When asked, this SSG cannot promise you that she will not harm herself before morning, when she is to consult with a mental health provider. What should you do?
5. Why is it important to ask a potentially suicidal person about their plan to harm themselves?

OPERATIONAL QUESTIONS and ANSWERS:

1. **What is the best way to deal with a suicidal Soldier who is not an imminent risk, that is a Soldier who is unlikely to harm him/herself or others within the next 24 hours?** *(Provide the Soldier with genuine care and support. Refer the Soldier to a mental health provider. Ensure that the Soldier cannot impulsively hurt him/herself by removing access to lethal means and maintaining the Soldier on unit watch until the crisis is over or until a mental health provider clears the Soldier to return to full duty status.)*

2. **How does one respond to this Soldier's statement that: "I am useless to my family… my children would be better off if I were dead". (***Ask direct questions such as, "Do you mean that you are considering suicide as an option?" or "How long have you been thinking of suicide?")*

3. **You are attempting to demonstrate that you truly care about the SSG. You say, "I know its tough right now, but this crisis is going to pass, and you will eventually feel better. Let's talk some more about this tomorrow". Is there anything wrong with this approach?** *(First of all, the SSG may get the feeling that you really do not understand her plight. She may feel that you are impatient or uncaring and do not have more time to spend with her. She may feel as if her problems are being dismissed as being unimportant. Many people commit suicide because they see no other way to solve their problems. There is nothing to prevent the SSG from hurting herself once you finish talking. "Tomorrow" holds no meaning to someone who is intent upon killing themselves. Any reassurance should take the form of, "I know some people who can help you with your problems, and I'm going to see that you get a chance to speak with them as soon as possible.")*

4. **When asked, this SSG cannot promise you that she will not harm herself before morning, when she is to consult with a mental health provider. What should you do?** *(Escort the Soldier to a mental health provider or a treatment facility with an emergency room).*

5. **Why is it important to ask a potentially suicidal person about their plan to harm themselves?** *(You need to know something about the plan so you can remove any potentially lethal items from the environment. For instance, if a Soldier states he plans to shoot himself, his weapon should be confiscated.)*

Scenario #8 - Post-Deployment

Supporting Soldiers, Families & Civilians – Active, Guard, Reserve and Retired

A 23 year old, active duty SPC is in a rehabilitation hospital after losing a leg to an IED in Iraq. He also sustained a mild concussion from the blast. His recovery has been complicated by an infection. Prior to losing his leg, he was a marathon runner who loved to run.

You are visiting this injured Soldier in the hospital.

You do not know:

1. He is feeling very hopeless about his future.
2. He told his girlfriend to stop visiting him.
3. He is feeling that he is a burden to his family.
4. He attempted suicide by a drug overdose two weeks ago
5. He has been stockpiling his pain medications.
6. He is undecided about killing himself.

During your conversation with this Soldier, he states, “I can’t live this way.”

STRATEGIC QUESTIONS:

1. With the current shortage of medical personnel, is it probably inevitable that medical staff will focus on the physical injuries, leaving the invisible psychological injuries untreated. How would you modify your policies and procedures to ensure that Soldiers like this one receive the psychological care they deserve?
2. As a health care provider, you are concerned that returning injured Soldiers seem to be withdrawing socially and distancing themselves from friends and loved ones. Would you make any changes in your treatment plans? If so, what kinds of changes?
3. How can one reduce the boredom and sense of hopelessness/helplessness experienced by Soldiers in Warrior Transition Units?
4. What is the best way to deal with individuals in WTU's who appear to be "padding their nest", i.e. presenting greater disability than can be accounted for on the basis of their injuries?
5. How can line officers and health care providers better cooperate to reduce suicides?

STRATEGIC QUESTIONS and ANSWERS:

1. **With the current shortage of medical personnel, is it probably inevitable that medical staff will focus on the physical injuries, leaving the invisible psychological injuries untreated. How would you modify your policies and procedures to ensure that Soldiers like this one receive the psychological care they deserve?** *(Make a routine psychological assessment part of the initial admission physical and schedule routine psychological follow-up sessions during the course of treatment. Do not have staff wait until a psychological crisis arises before obtaining mental health services. Educate staff regarding dual- and multiple diagnosis cases and the needs of such cases for early mental health intervention.)*

2. **As a health care provider, you are concerned that returning injured Soldiers seem to be withdrawing socially and distancing themselves from friends and loved ones. Would you make any changes in your treatment plans? If so, what kinds of changes?** *(for discussion).*

3. **How can one reduce the boredom and sense of hopelessness/helplessness experienced by Soldiers in Warrior Transition Units?** *(Find meaningful work and activities for the Soldier's when they are not being treated.)*

4. **What is the best way to deal with individuals in WTU's who appear to be "padding their nest", i.e. presenting greater disability than can be accounted for on the basis of their injuries?** *(First, understand that, if an error in judgment is to be made, it is better to err on the side of the Soldier. Secondly, it is often very difficult to differentiate between malingering and factitious disorders [disorders wherein medical complains appear to be expressed for the sole purpose of gaining the attention of health care providers]. Also understand that many Soldiers feel, perhaps justifiably, that they will be "short-changed" by the Medical Evaluation Board. Thus, in order to receive "justice", they must present with an overabundance of symptoms so that, in the end, they will be properly reimbursed. If malingering can be firmly established, the Soldier should be confronted and made aware of the consequences of such behavior. However, it will frequently take some sort of "face-saving" maneuver to permit such individuals to gracefully give up their excess symptoms).*

5. **How can line officers and health care providers better cooperate to reduce suicides?** *(for discussion).*

TACTICAL QUESTIONS:

1. As this unit's commander, you are surprised to find yourself thinking about suicide. Your mission has been brutal on you and your Soldiers. You have lost a number of Soldiers. The demands on you are incredible, and you cannot seem to obtain adequate rest. You find yourself easily distracted. You have lost about 20 pounds over the past 3 months. You have concerns that your wife is not being faithful, and you miss your children. On top of all this, your First Sergeant informs you that the SPC is probably suicidal and almost certainly depressed. What is your course of action?
2. How do you, as the unit Commander, "keep your hand on the pulse" of your unit's psychological health?
3. How does one, as in this case, sever ties with a unit member who is going to be medically boarded in such a way as to maintain unit morale while also contributing to the psychological health of the separated soldier? Is this even possible? Is it even desirable?
4. The Soldier appears to be withdrawing socially. He has asked his girlfriend not to visit, and he has requested that staff not permit you to visit him. How should you respond?
5. Do you gauge the capability, as the unit commander, to influence the course of this SPC's treatment and recovery? How?

TACTICAL QUESTIONS and ANSWERS:

1. **As this unit's commander, you are surprised to find yourself thinking about suicide. Your mission has been brutal on you and your Soldiers. You have lost a number of Soldiers. The demands on you are incredible, and you cannot seem to obtain adequate rest. You find yourself easily distracted. You have lost about 20 pounds over the past 3 months. You have concerns that your wife is not being faithful, and you miss your children. On top of all this, your First Sergeant informs you that the SPC is probably suicidal and almost certainly depressed. What is your course of action?** *(Let your first sergeant handle the suicidal specialist. He/she is more than capable. You must also take care of yourself. Consultation with a mental health provider is likely to prove useful. If you are reluctant to seek assistance, what will your Soldiers feel about seeking assistance? If you are worried that your Soldiers will learn of your consultation, don't worry. You are setting a healthy example for them, and you are helping demystify and de-stigmatize mental health services. Overall, you and your unit will be better off if you take the time to take care of yourself.)*
2. **How do you, as the unit Commander, "keep your hand on the pulse" of your unit's psychological health?** *(Socrates was a wise man indeed. First, know yourself. Do you feel uncomfortable talking about mental health issues either because you feel untrained or because you find such discussions meaningless or because such discussions raise your own level of anxiety? You must know your Soldiers. You must have an NCO staff that freely communicates both up and down the chain-of-command. You must provide an atmosphere in which Soldiers feel free to discuss any of their problems without fear of retribution, embarrassment, or punishment. You must give as much attention to the mental health of Soldiers as you do to their physical health. Your Soldiers must feel they can trust you to protect them physically AND psychologically.)*
3. **How does one, as in this case, sever ties with a unit member who is going to be medically boarded in such a way as to maintain unit morale while also contributing to the psychological health of the separated soldier? Is this even possible? Is it even desirable?** *(No right or wrong answers. For discussion).*
4. **The Soldier appears to be withdrawing socially. He has asked his girlfriend not to visit, and he has requested that staff not permit you to visit him. How should you respond?** *(Discuss this concern with the treating mental health specialist and /or his treating physician or the treatment team. They may need you and the Soldier's girlfriend to continue visiting the patient, in spite of the Soldier's requests, as part of his rehabilitation. This Soldier has experienced some significant losses, and he is angry. Unfortunately he is inappropriately expressing his anger toward you and his girlfriend. Do not take offense. This soldier's treatment team, if they practice according to community standards, has already performed a thorough evaluation, including a psychological evaluation, on the Soldier. Since you are unaware that the Soldier is stockpiling his medications, you can do nothing more than express concern, for the soldier, to the treatment team.*
5. **Do you gauge the capability, as the unit commander, to influence the course of this SPC's treatment and recovery? How?** *(For discussion).*

OPERATIONAL QUESTIONS:

1. How do you respond when the Soldier states, “I can’t live this way”?
2. If the Soldier responds that he has thought about committing suicide, how would you determine the degree of risk involved?
3. After talking to this Soldier, you feel he is not at an imminent risk to harm himself. What should you do next?
4. Learning that you have “told on him”, the Soldier becomes very angry with you, demanding that you leave him alone and calling you names. How should you respond?
5. The Soldier reveals, during the course of your conversation, that he has been stockpiling his medications “…just in case”. What should your response be?

OPERATIONAL QUESTIONS and ANSWERS:

1. **How do you respond when the Soldier states, "I can't live this way"?** *(Help him clarify his thoughts by **ask**ing questions, such as "What do you mean by that?", "Are you considering hurting yourself?", "Have you spoken to anyone about these feelings?")*

2. **If the Soldier responds that he has thought about committing suicide, how would you determine the degree of risk involved?** *(Determine if the Soldier is at imminent risk by asking him if he has plans to harm himself and if he really intends to carry out these plans. **Ask** about commonly known risk factors such as previous suicide attempts, depression, social withdrawal, etc.)*

3. **After talking to this Soldier, you feel he is not at an imminent risk to harm himself. What should you do next?** *(Understand that you are not qualified, by virtue of training or experience, to make a judgment regarding the degree of risk. Convey your sincere concern and care for him. Try to get the Soldier to speak with a Chaplain or mental health provider about his feelings. If the Soldier refuses or gives you a lukewarm response, you should report the Soldier's suicidal thoughts to his treatment team, his commander, a mental health provider, or a Chaplain. Remember, since you do not have a therapeutic relationship with this Soldier, you are not bound by rules related to confidentiality. In fact, the Soldier may be secretly hoping that you will report his suicidality, feeling unable to do so himself).*

4. **Learning that you have "told on him", the Soldier becomes very angry with you, demanding that you leave him alone and calling you names. How should you respond?** *(Do not become angry in response. Understand that the Soldier is appropriately angry regarding his circumstances and that he is inappropriately directing that anger towards you. Reassure the Soldier that you care for him and that you are available if he needs you. You might consider revisiting him once he has had time to cool off.)*

5. **The Soldier reveals, during the course of your conversation, that he has been stockpiling his medications "…just in case". What should your response be?** *(Express **care** for the Soldier by telling him you are either going to remove the stockpile of pills, or you are going to have the hospital staff remove them.)*

Scenario #9 - R&R

Supporting Soldiers, Families & Civilians – Active, Guard, Reserve and Retired

A 23 year old, active duty SPC has been deployed to Afghanistan for 8 months. He is going home on R & R and wants to surprise his family and girlfriend. In fact, he hopes to propose marriage to his girlfriend of four years. Upon arrival, he learns that his girlfriend is pregnant by another man. He is devastated.

You are a friend of this SM.

You do not know:

1. This SM is very depressed.
2. This SM is abusing alcohol.
3. He feels as though there is nothing else to live for.
4. He has purchased a weapon.

During the conversation, this SM states, “While in Afghanistan, thinking about her helped me to cope. I can’t see myself living without her.”

STRATEGIC QUESTIONS:

1. As a Commander establishing a suicide prevention program, to what degree do you consider generational differences, such as “baby-boomers” versus “generation X”?
2. The Army seems to have provided significant resources to assist the spouse and children of deployed service members. However, there do not appear to be similar agencies/policies to support the significant others of unmarried Soldiers. Is this fair? What more can we, as an organization, do to help support these people?
3. The Army and her sister services recruit mostly from a pool of young, unskilled individuals. Such individuals, in general, also tend to be socially unskilled. Moreover, we are now recruiting more individuals with criminal backgrounds, pre-existing psychological problems, and lower intellectual skills. Are there ways we can accelerate the social maturity of such individuals, or do we have to wait for development to take it’s time? Does the Army currently have any mechanism for increasing the social skills and maturity of new Soldiers? If so, what are these mechanisms? What additional measures can the Army take to increase the resilience and social maturity of these individuals?
4. How does a Commander promote help-seeking behaviors within his/her organization?
5. How does a Commander monitor his/her unit for possible suicidal intent?

STRATEGIC QUESTIONS and ANSWERS:

1. **As a Commander establishing a suicide prevention program, to what degree do you consider generational differences, such as "baby-boomers" versus "generation X"? (***While it is true that certain age groups, most notable 25 and under and 65 and above have higher rates of suicide, the National Academy of Sciences, in response to a request for information from Army senior leadership, has noted that there is no scientific evidence for significant generational differences in behaviors and attitudes. Thus, the much heralded generational differences should not be a consideration when designing a suicide prevention program***.)**

2. **The Army seems to have provided significant resources to assist the spouse and children of deployed service members. However, there do not appear to be similar agencies/policies to support the significant others of unmarried Soldiers. Is this fair? What more can we, as an organization, do to help support these people? (***for discussion).*

3. **The Army and her sister services recruit mostly from a pool of young, unskilled individuals. Such individuals, in general, also tend to be socially unskilled. Moreover, we are now recruiting more individuals with criminal backgrounds, pre-existing psychological problems, and lower intellectual skills. Are there ways we can accelerate the social maturity of such individuals, or do we have to wait for development to take it's time? Does the Army currently have any mechanism for increasing the social skills and maturity of new Soldiers? If so, what are these mechanisms? What additional measures can the Army take to increase the resilience and social maturity of these individuals?** *(for discussion***).**

4. **How does a Commander promote help-seeking behaviors within his/her organization?** *(First and foremost, the Commander must him/her-self believe that help-seeking behaviors are healthy. This belief must then be accepted at all echelons. He/she must take all measures to reduce any stigma attached to help-seeking behavior. Taunting or teasing someone who has sought assistance must be eliminated.)*

5. **How does a Commander monitor his/her unit for possible suicidal intent?** *(First, know your Soldiers and their families so you can recognize or even anticipate behavioral problems. Promote the buddy system. Train your NCO's to know and monitor their Soldiers. Create an atmosphere of inclusion and acceptance for all unit members Know the warning signs for suicide: loneliness, worthlessness, hopelessness, etc. Talk with your Soldiers following any major change in their life circumstances.)*

TACTICAL QUESTIONS:

1. Other Soldiers are the first line of defense in the Army's suicide prevention program. How do you prepare yourself for this role? What behaviors must you master in order to fulfill this role?

2. How much training in suicide prevention is enough? How much can realistically fit into your training schedule? How frequently should such training be given? How should new arrivals to your unit be included in this process? When can one stop training in suicide prevention?

3. Is suicide a medical or Command problem. How can behavioral health specialists and unit Commanders best work together to reduce the occurrence of suicidal behaviors?

4. As a unit commander, do you think someone who has been psychiatrically hospitalized for suicidal behaviors can ever be successfully reintegrated into the unit?

5. What kind(s) of training do you think is necessary to "harden up" Soldiers, make them more resilient, and make them less vulnerable to suicidal impulses? Do you think BATTLEMIND is enough to reduce suicidal behaviors?

TACTICAL QUESTIONS and ANSWERS:

1. **Other Soldiers are the first line of defense in the Army's suicide prevention program. How do you prepare yourself for this role? What behaviors must you master in order to fulfill this role?** *(Know the warning signs of suicide. Know the leading causes of suicide, Be constantly vigilant. Take immediate action when you suspect that someone may be suicidal. Use ACE. Be aware of the resources available to assist the Soldier. Use the expertise of your chain-of-command. Help promote the view that help-seeking behaviors are healthy and a sign of courage, strength, and intelligence.)*

2. **How much training in suicide prevention is enough? How much can realistically fit into your training schedule? How frequently should such training be given? How should new arrivals to your unit be included in this process? When can one stop training in suicide prevention?** *(for discussion; training can never be stopped)*

3. **Is suicide a medical or Command problem. How can behavioral health specialists and unit Commanders best work together to reduce the occurrence of suicidal behaviors?** *(there may be disagreement, but suicide appears to be a Command problem in that Commanders have the means to create a supportive and caring environment. The behavioral health provider is best viewed as a consultant to the unit Commander, providing the Commander with information to help him/her make personnel management decisions)*

4. **As a unit commander, do you think someone who has been psychiatrically hospitalized for suicidal behaviors can ever be successfully reintegrated into the unit?** *(for discussion).*

5. **What kind(s) of training do you think is necessary to "harden up" Soldiers, make them more resilient, and make them less vulnerable to suicidal impulses? Do you think BATTLEMIND is enough to reduce suicidal behaviors?** *(again, for discussion).*

OPERATIONAL QUESTIONS:

1. How would you employ the ACE strategy to help this service member?
2. What risk factors are present to suggest that this individual may act impulsively to harm himself?
3. Since you do not know about these risk factors, how are you going to make a judgment regarding this Soldier's needs?
4. Once your friend conveys possible suicidal ideation to you, do you have a moral, ethical, or legal obligation to him?
5. How does one know when the acute danger of suicide has passed?

OPERATIONAL QUESTIONS and ANSWERS:

1. **How would you employ the ACE strategy to help this service member?** *(**Ask** him about any possible suicidal feelings. Do not be satisfied with an initial, "No". If he is indeed suicidal, **care** for him by removing any means of inflicting self harm and **escort** him to a mental health provider. If he is not suicidal, he may still need mental health services to assist him in dealing with his current depression and loss.)*

2. **What risk factors are present to suggest that this individual may act impulsively to harm himself?** *(He has the means, i.e. a weapon. He is depressed and probably not thinking clearly, and he is abusing alcohol. He feels hopeless and does not see alternatives available to him.)*

3. **Since you do not know about these risk factors, how are you going to make a judgment regarding this Soldier's needs?** *(You are not going to make such a judgment; you will leave that to the professionals. Your job is to get your friend to those professionals. However, in determining your course of action, always be conservative, erring if necessary in the direction of safety. Given the information you DO have, it would be wise to escort your friend to a mental health provider's, or a Chaplain's, office for further evaluation. You already have indications of suicidal thought, given the Soldier's statement to the effect, "…I can no longer cope; I can't live without her.")*

4. **Once your friend conveys possible suicidal ideation to you, do you have a moral, ethical, or legal obligation to him?** *(In this scenario, one certainly has an ethical obligation to his/her friend. Helping your friend is certainly the "right" thing to do. In terms of morality, any obligation you have would depend upon your own personal beliefs and attitudes. Any legal obligation would be defined by Army regulation and/or local policies and procedures.)*

5. **How does one know when the acute danger of suicide has passed?** *(The mental health professional, Chaplain, or chain-of-command will let you know.)*

Scenario #10 – Pre-deployment

Supporting Soldiers, Families & Civilians – Active, Guard, Reserve and Retired

You are the friend of a 34 year old Reserve Captain who has been passed over for a promotion. Your friend was unexpectedly called-up to deploy. He cannot afford to deploy because of his huge mortgage payment. If deployed, your friend would need to sell his house, because his Army pay would be inadequate to cover the mortgage. His spouse thinks he volunteered for deployment and threatens to leave him if he sells the house.

You are talking with your friend.

You do not know:

1. He is feeling very hopeless about his situation.
2. He has recently increased his life insurance.
3. He has frequent thoughts about dying in combat so his family can collect the life insurance.

At some point in the conversation, your friend says, “If I die, my life insurance will pay off the mortgage on my house. My family will always have a place to live.”

STRATEGIC QUESTIONS:

1. As an organization, how can we better support our reservists and guardsmen who are called to active duty?
2. In cases such as this, can we make necessary services available to reservists and guardsmen BEFORE and AFTER they enter active duty? Why or why not?
3. In what ways can we better support the families of reservists and guardsmen on active duty?
4. When should reservists and guardsmen receive training in suicide prevention?
5. Do you think reservists and guardsmen experience unique stressors that could place them at increased risk of suicide? Why or why not?

STRATEGIC QUESTIONS and ANSWERS:

1. **As an organization, how can we better support our reservists and guardsmen who are called to active duty?** *(for discussion)*

2. **In cases such as this, can we make necessary services available to reservists and guardsmen BEFORE and AFTER they enter active duty? Why or why not?** *(for discussion)*

3. **In what ways can we better support the families of reservists and guardsmen on active duty?** *(for discussion).*

4. **When should reservists and guardsmen receive training in suicide prevention?** *(Before, during, and after each deployment.)*

5. **Do you think reservists and guardsmen experience unique stressors that could place them at increased risk of suicide? Why or why not?** *(for discussion*

TACTICAL QUESTIONS:

1. As reservists and guardspersons are assigned to your unit, what kinds of things can you do to decrease their risk of suicide?
2. You have learned that this Captain is feeling hopeless and has entertained some thoughts of suicide. You decide to counsel him. What kinds of things would you, as his Commander, say? What kind of referrals might you make? Are there other resources available to help this officer solve his problems in a more appropriate manner?
3. In talking with this young officer, he states that he feels overwhelmed and that he fears his decision-making might be impaired. He does not know how to get back on track and, though he is not currently suicidal. He keeps having recurrent, intrusive thoughts about what it might be like to be dead. He has begun to question the meaning of life. He states he cannot guarantee that he will not, at some point in the future, engage in suicidal behaviors. What do you do?
4. The Captain takes your advice and seeks mental health consultation. He is placed on antidepressant medications. However, six weeks later, he feels no better and continues to experience his symptoms. What should you do next?
5. The mental health provider ultimately decides that hospitalization is in the Captain's bests interest. Realistically, do you feel this Captain can return from his hospitalization and successfully be reintegrated into his leadership position?

TACTICAL QUESTIONS and ANSWERS:

1. **As reservists and guardspersons are assigned to your unit, what kinds of things can you do to decrease their risk of suicide?** *(Get to know them, their needs, their expectations, and their fears/anxieties. Ensure that they have received training in BATTLEMIND and suicide prevention. Social gatherings might also be used to assist the newly assigned Soldiers in feeling accepted as part of the team. Help them feel assured that you will be looking out for their interests and that problems can be voiced without fear of retribution or ridicule.)*

2. **You have learned that this Captain is feeling hopeless and has entertained some thoughts of suicide. You decide to counsel him. What kinds of things would you, as his Commander, say? What kind of referrals might you make? Are there other resources available to help this officer solve his problems in a more appropriate manner?** *(for discussion).*

3. **In talking with this young officer, he states that he feels overwhelmed and that he fears his decision-making might be impaired. He does not know how to get back on track and, though he is not currently suicidal. He keeps having recurrent, intrusive thoughts about what it might be like to be dead. He has begun to question the meaning of life. He states he cannot guarantee that he will not, at some point in the future, engage in suicidal behaviors. What do you do?** *(Refer this officer to mental health providers. Assure the Captain that there will be no negative consequences for seeking mental health consultation.)*

4. **The Captain takes your advice and seeks mental health consultation. He is placed on antidepressant medications. However, six weeks later, he feels no better and continues to experience his symptoms. What should you do next?** *(Your should obtain, from the Captain, authority to discuss his problems with his mental health provider. Next, consult with the provider to determine the best course of action. Hospitalization might be required.)*

5. **The mental health provider ultimately decides that hospitalization is in the Captain's bests interest. Realistically, do you feel this Captain can return from his hospitalization and successfully be reintegrated into his leadership position?** *(for discussion)*

OPERATIONAL QUESTIONS:

1. In response to your friend's statement that his life insurance will pay off the mortgage in the event of his death, how should you respond to your friend?
2. Your friend, in response to your questioning replies, "Oh…I'm not thinking of suicide. I could never do that. I love my family too much." How might you respond?
3. In response to your statements, the friend says, "You know, I never thought of that. You might be right!" What might you say now?
4. Why did you not escort your friend immediately to a mental health provider?
5. Your friend elects not to seek assistance, and his condition continues to decay. He has taken to drinking heavily, and he seems to cry at the drop of a hat. He speaks to you very infrequently. His wife states he has purchased a handgun. He eats only rarely and has lost about 20 pounds. What should you do?

OPERATIONAL QUESTIONS and ANSWERS:

1. **In response to your friend's statement that his life insurance will pay off the mortgage in the event of his death, how should you respond to your friend?** *(His statement is ambiguous in terms of intent to harm himself. It is obvious that he is experiencing intense distress. The next step would be to clarify your friend's statements by asking such questions as, "…are you going to intentionally put yourself in danger? Are you thinking about suicide?; Are you intending to die?"*

2. **Your friend, in response to your questioning replies, "Oh…I'm not thinking of suicide. I could never do that. I love my family too much." How might you respond?** *(A good response would be, "Well, I'm glad to hear that. However, I wonder if all this stress may preoccupy you to the point that you might be distracted while in theater. That could put you at greater risk of being injured or killed.".)*

3. **In response to your statements, the friend says, "You know, I never thought of that. You might be right!" What might you say now?** *(Well then, you might take some time now, before you deploy, to try to resolve some of your problems. You could speak to a JAG officer regarding your legal rights while deployed. You and your wife could also get some assistance with your marital difficulties, though it sounds like the marriage will be much better once she no longer has to fear losing the house.)*

4. **Why did you not escort your friend immediately to a mental health provider?** *(While your friend is experiencing a tremendous amount of stress, he has not said anything to indicate that he is in imminent danger to himself or others. Through your questioning, you have determined that your friend wants to live; he is just experiencing some vague thoughts about dying in order to save his family. You have directed him to sources of assistance, and he appears motivated to resolve his problems.)*

5. **Your friend elects not to seek assistance, and his condition continues to decay. He has taken to drinking heavily, and he seems to cry at the drop of a hat. He speaks to you very infrequently. His wife states he has purchased a handgun. He eats only rarely and has lost about 20 pounds. What should you do?** *(In this case, where you suspect that your friend is suicidal but not imminently suicidal, you might consult with a mental health professional regarding your best course of action. You could also speak to your friend again to reassess his potential for self harm. You could speak with his wife regarding your concerns. However, she may be as confused as you are. Perhaps she can locate the handgun and remove it (caring) from the house while your friend is so depressed. You could also insist that your friend accompany you (escort) to a mental health provider or an emergency room. The key issue here is that your friend is technically a civilian and cannot have his civil rights taken from him unless he is IMMINENTLY dangerous to himself or others.)*

Scenario #11 – Basic Training Brigade

Supporting Soldiers, Families & Civilians – Active, Guard, Reserve and Retired

You are the sergeant major of a basic training battalion. You notice that your Commander, an infantry LTC in his late 40's, has become increasingly irritable. His appearance has also begun to deteriorate, and he frequently arrives to work unshaven and in a dirty uniform. He complains that this assignment has gotten "TRADOC Slime" on him and that he will never again be able to get a good assignment. During your conversations with him, you notice that he is easily distracted and his mind seems to be elsewhere. He is having trouble remembering his schedule. He has stopped his morning runs and has gained about 20 pounds over the past few months. During one conversation, he described to you an incident which occurred while he worked in the US embassy in Egypt. He states that Bulgarian agents kidnapped him and held him for ransom. He states the incident was not publicized because of possible political ramifications. The LTC has also been "called on the carpet" recently because there was a trainee suicide within his battalion. He stated, "My career is over." He occasionally falls asleep in his office. On one occasion, you inadvertently discovered him crying in his office.

What you do not know:

1. The LTC is having marital problems.
2. His eldest son just flunked out of college.
3. The LTC has been experiencing frequent, intrusive thought of suicide.
4. The LTC's sleep has been highly fragmented.
5. The LTC has recently been passed over for promotion.

At some point in the conversation, the LTC states, "I don't know if it's worth it to continue."

STRATEGIC QUESTIONS:

1. While suicide rates seem to be escalating among younger soldiers, there seems to be less attention, in terms of suicide prevention, to the psychological health of more senior leadership. Do you agree or disagree with this contention. If you agree, what recommendations can you make?
2. Is the stigma regarding mental health services disproportionately high among our more senior leadership? Why or why not?
3. Do you think routine mental health evaluations should be required for all personnel just as routine physical examinations are required? Why or why not?
4. Do you think that such periodic “psychological examination” could help reduce the stigma regarding mental health services? Why or why not? (for discussion)
5. Do you think that some people are, by nature, more vulnerable to the effects of distressing events? Should we, as an organization, “weed out”, or at least identify, the weaker people? Why or why not?

STRATEGIC QUESTIONS and ANSWERS:

1. **While suicide rates seem to be escalating among younger soldiers, there seems to be less attention, in terms of suicide prevention, to the psychological health of more senior leadership. Do you agree or disagree with this contention. If you agree, what recommendations can you make?** *(Suicide rates are highest among the youngest and oldest Soldiers. Discuss what to do for more senior Soldiers to prevent suicide.)*
2. **Is the stigma regarding mental health services disproportionately high among our more senior leadership? Why or why not?** *(for discussion).*
3. **Do you think routine mental health evaluations should be required for all personnel just as routine physical examinations are required? Why or why not?** *(for discussion).*
4. **Do you think that such periodic "psychological examination" could help reduce the stigma regarding mental health services? Why or why not?** *(for discussion)*
5. **Do you think that some people are, by nature, more vulnerable to the effects of distressing events? Should we, as an organization, "weed out", or at least identify, the weaker people? Why or why not?** *(people differ on any number of dimensions such as height, weight, hair color, etc.; they also differ in terms of their ability to tolerate distress; some individuals are more sensitive, reactive, and impulsive than others; additionally, some behavioral disorders like depression may have a genetic basis, with some individuals being more prone to develop behavioral problems. Even though an individual might possess some"weaknesses" as all people do, their strengths should also be considered. What if we "weeded out all people with red hair?).*

TACTICAL QUESTIONS:

1. How do you, as the brigade Commander, promote compassionate suicide prevention attitudes while at the same time fostering discipline and trying to reduce trainee attrition? Are these mutually exclusive goals? Does one goal interfere with the attainment of other goals? Explain.
2. As the brigade Commander, how do you respond when representatives from the Army medical center approach you requesting two hours to test all trainees as part of a research project designed to reduce suicide rates?
3. With the Army accepting increasing numbers of trainees with criminal histories, lower aptitude scores, and more moral waivers, how do you modify your suicide prevention program, if indeed it is necessary to modify it at all, to keep suicides to a minimum among your trainees?
4. You have noticed that a fairly sizable percentage of trainees report to the Community Mental Health Service seeking discharge because they are “suicidal”. This percentage has increased since one trainee was indeed discharged for a personality disorder after complaining of suicidal thoughts. You assume, probably rightly so, that the increase is due to a “copy-cat” effect, and the local MEDDAC Commander is complaining that his mental health resources are being stretched to the point of breaking. How do you respond to this situation without increasing the stigma attached to the seeking of mental health services, without discouraging individuals with bona fide problems from seeking services, without increasing the burden upon the Community Mental Health Service, and without compromising your training standards?
5. How do you train your staff to be compassionate and to respond to requests for mental health consultation without ridicule or retribution while still maintaining discipline and training standards? Is this even a problem?

TACTICAL QUESTIONS and ANSWERS:

1. **How do you, as the brigade Commander, promote compassionate suicide prevention attitudes while at the same time fostering discipline and trying to reduce trainee attrition? Are these mutually exclusive goals? Does one goal interfere with the attainment of other goals? Explain.** *(for discussion)*

2. **As the brigade Commander, how do you respond when representatives from the Army medical center approach you requesting two hours to test all trainees as part of a research project designed to reduce suicide rates?** *(One would hope that you would be as cooperative as is reasonably possible. It is understood that we, as an organization, make numerous demands on training time and that yet another such demand would create scheduling and logistic problems. Yet, the psychological health and cognitive abilities are extremely important, especially on the postmodern battlefield. Advances in Soldier psychological abilities will not occur without additional research. As a Commander, you must balance current time demands for training against future organizational improvement.)*

3. **With the Army accepting increasing numbers of trainees with criminal histories, lower aptitude scores, and more moral waivers, how do you modify your suicide prevention program, if indeed it is necessary to modify it at all, to keep suicides to a minimum among your trainees?** *(for discussion)*

4. **You have noticed that a fairly sizable percentage of trainees report to the Community Mental Health Service seeking discharge because they are "suicidal". This percentage has increased since one trainee was indeed discharged for a personality disorder after complaining of suicidal thoughts. You assume, probably rightly so, that the increase is due to a "copy-cat" effect, and the local MEDDAC Commander is complaining that his mental health resources are being stretched to the point of breaking. How do you respond to this situation without increasing the stigma attached to the seeking of mental health services, without discouraging individuals with bona fide problems from seeking services, without increasing the burden upon the Community Mental Health Service, and without compromising your training standards?** *(for discussion; however it should be noted that first line personnel and Commanders are not qualified, by virtue of training or experience, to determine whether or not any individual trainee is truly suicidal or just malingering.)*

5. **How do you train your staff to be compassionate and to respond to requests for mental health consultation without ridicule or retribution while still maintaining discipline and training standards? Is this even a problem?** *(for discussion)*

OPERATIONAL QUESTIONS:

1. As LTC's Commander, you also note changes in his demeanor and mood? What should you do?
2. Even after consulting with his boss, the LTC seems to continue to deteriorate. As his sergeant major, what would your best course of action be?
3. In your attempt to talk to the LTC, he remarks, "Don't give me that suicide sissy prevention crap. If I'm going to commit suicide, no one will know beforehand. The only reason you're here is because I do your EER. Besides, my problems are none of your business." How do you respond now?
4. The LTC comes in one morning and says, "Thanks a lot for tattle-telling on me! Now I've been ordered to report to the Community Mental Health Service for a mental status examination! Do you have any idea how humiliating that is? Do you have any idea what this is going to do to my career? Why couldn't you just mind your own business?" How do you respond?
5. The next morning you learn that the LTC had gone to one of the ranges and died from a self-inflicted gunshot would to his head. How do you respond?

OPERATIONAL QUESTIONS and ANSWERS:

1. **As LTC's Commander, you also note changes in his demeanor and mood? What should you do?** *(Sit down with the LTC and have a frank, nonjudgmental conversation about your observations. Express genuine concern for him.* ***Ask*** *him directly if he has been depressed or if he has had thought of suicide and respond appropriately.)*

2. **Even after consulting with his boss, the LTC seems to continue to deteriorate. As his sergeant major, what would your best course of action be?** *(Bring your concerns to his attention, and try to get him to consult with a mental health professional. If he does not respond appropriately, you should probably bring this to the brigade sergeant major.)*

3. **In your attempt to talk to the LTC, he remarks, "Don't give me that suicide sissy prevention crap. If I'm going to commit suicide, no one will know beforehand. The only reason you're here is because I do your EER. Besides, my problems are none of your business." How do you respond now?** *(Obviously, you try to convince the LTC of your genuine concern. At this point, you might consider speaking with the brigade commander.)*

4. **The LTC comes in one morning and says, "Thanks a lot for tattle-telling on me! Now I've been ordered to report to the Community Mental Health Service for a mental status examination! Do you have any idea how humiliating that is? Do you have any idea what this is going to do to my career? Why couldn't you just mind your own business?" How do you respond?** *(You might want to apologize, stating you were motivated only by your genuine concern regarding his current emotional state. You might also point out that you respect him as a Soldier and that you enjoy working under him. You might also say, "I'd hope you'd do the same thing for me if I were having difficulties." Essentially, you want to normalize the situation as much as possible and to make sure the LTC knows that you are available if he ever wants to talk.)*

5. **The next morning you learn that the LTC had gone to one of the ranges and died from a self-inflicted gunshot would to his head. How do you respond?** *(Contact the family to see if there is anything you can do for them. Assess the emotional impact this event has had on you. Do you feel in any way responsible for what happened? You might want to seek a mental health provider to assist you in processing this event. You also want to assess the effect this event has had on your Soldier's and NCO's. It might be worth your while to consult with a mental health provider regarding the best way to help your Soldiers and NCO's deal with the Commander's death. Conduct an after action investigation with the other parties to see if there were things that could have been done differently to prevent this tragedy.)*

Scenario #12 – Deployed PFC

PFC Jones has been the subject of considerable verbal abuse and bullying by SPC Smith. On several occasional, PFC Jones has come to you, as her battle buddy, crying and complaining of the treatment she is receiving at the hands of SPC Smith. On more than one occasion, you have spoken with SPC Smith and asked her to stop bullying PFC Jones. This morning, SPC Smith told Jones that she would "…come for her tonight and teach her a lesson." Hearing this, you tell your platoon sergeant what is happening. She promises to speak with SPC Smith and, indeed, she orders SPC Smith to stay away from, and stop bullying, PFC Jones. That night, SPC Smith went to PFC Jones' room and beat her severely, though not severely enough to require medical treatment. A bloody and bruised PFC Jones comes to you and states, "I just can't take this any more!"

What you don't know:

1. PFC Jones has a history of being abused physically and emotionally.
2. PFC Jones just received a "Dear Jane Letter".
3. PFC Jones' mother is quite ill.
4. PFC Jones has been periodically having thought of suicide.

At one point in your conversation, PFC Jones states, "It's just not worth it any more."

STRATEGIC QUESTIONS:

1. The Army accepts a number of younger individuals who vary in their maturity, intellect, and social skills. As senior leadership, what more, if anything, can we do to create an environment wherein all Soldiers feel safe. Is this even a practical goal? After all, the civilian streets are dangerous places too.
2. We want Soldiers to be appropriately aggressive. What do you feel is the best way for the organization to respond to hazing, harassment, and assaults? Is the JAG the best office to deal with such events? Should there be some sort of incident reporting, or surveillance system, for Soldier on Soldier aggression?
3. How do we help Soldiers distinguish appropriate from inappropriate aggression?
4. Does the battle buddy system work? Why or why not? Are there solid data to support the battle buddy system?
5. Is there some practical way to identify “at-risk” individuals before they enlist? Would doing so reduce the suicide risk? Could such a system have secondary benefits?

STRATEGIC QUESTIONS and ANSWERS:

1. **The Army accepts a number of younger individuals who vary in their maturity, intellect, and social skills. As senior leadership, what more, if anything, can we do to create an environment wherein all Soldiers feel safe. Is this even a practical goal? After all, the civilian streets are dangerous places too.** *(for discussion).*

2. **We want Soldiers to be appropriately aggressive. What do you feel is the best way for the organization to respond to hazing, harassment, and assaults? Is the JAG the best office to deal with such events? Should there be some sort of incident reporting, or surveillance system, for Soldier on Soldier aggression?** *(for discussion).*

3. **How do we help Soldiers distinguish appropriate from inappropriate aggression?** *(for discussion)*

4. **Does the battle buddy system work? Why or why not? Are there solid data to support the battle buddy system?** *(for discussion)*

5. **Is there some practical way to identify "at-risk" individuals before they enlist? Would doing so reduce the suicide risk? Could such a system have secondary benefits?** *(Previous efforts to identify at-risk individuals have failed. However, psychological testing is much more sophisticated today and, with sufficient research, a relative risk value can be assigned to Soldiers, permitting more precise allocation of resources to those Soldiers needing them. There will always be some degree of error when making predictions, but there is a certain, probably larger degree of error in our current system. Secondary benefits in attrition reduction may also be seen.)*

TACTICAL QUESTIONS:

1. Why do you think command did not take quicker action in this case?
2. What can be done to remove obstacles to the free flow of information up and down the chain-of-command?
3. Apparently PFC Jones did not disclose the facts that she had been abused, that she received a “Dear Jane” letter, or that her mother was seriously ill. Some people are more shy and reserved, not wanting to “burden” others with their personal problems. How can we identify such individuals and make them feel comfortable discussing their problems with their chain-of-command?
4. What went wrong, causing this situation to reach a flash point?
5. PFC Jones is discharged three days after being admitted to the psychiatric unit. You ask her how she is doing, and she replies, “I convinced them that I was not suicidal, and they let me go. However, I am not going to put up with SPC Smith’s abuse.” What should you do?

TACTICAL QUESTIONS and ANSWERS:

1. **Why do you think command did not take quicker action in this case?** *(For discussion)*

2. **What can be done to remove obstacles to the free flow of information up and down the chain-of-command?** *(for discussion)*

3. **Apparently PFC Jones did not disclose the facts that she had been abused, that she received a "Dear Jane" letter, or that her mother was seriously ill. Some people are more shy and reserved, not wanting to "burden" others with their personal problems. How can we identify such individuals and make them feel comfortable discussing their problems with their chain-of-command?** *(for discussion)*

4. **What went wrong, causing this situation to reach a flash point?** *(for discussion)*

5. **PFC Jones is discharged three days after being admitted to the psychiatric unit. You ask her how she is doing, and she replies, "I convinced them that I was not suicidal, and they let me go. However, I am not going to put up with SPC Smith's abuse." What should you do?** *(repeat the ACE procedures as necessary).*

OPERATIONAL QUESTIONS:

1. How do you clarify what PFC Jones means when she states, “It’s just not worth it any more.”
2. During your probe, PFC Jones admits she has been having thoughts about suicide. What do you do now?
3. PFC Jones states that she intend to take an overdose of pills and then shoot herself in the head with her rifle. How do you respond?
4. The treating physician comes out to you and states “PFC Jones is definitely suicidal and she has eloped from the emergency room.” What do you do?
5. PFC Jones is found and admitted to the psychiatric ward. Can you help her even while she is hospitalized? If so, how?

OPERATIONAL QUESTIONS and ANSWERS:

1. **How do you clarify what PFC Jones means when she states, "It's just not worth it any more."** *(You must ask probing questions to make sure you understand her correctly. Is she just expressing frustration or is making a cry for help. Ask her if she is feeling like harming herself. Don't take a quick "no" for a response. You can say things such as "This is an important question, and I want you to give me a thoughtful response" or "I care for you, and I want to make sure you're safe".)*

2. **During your probe, PFC Jones admits she has been having thoughts about suicide. What do you do now?** *(Ask her if she has gone so far as to make a plan and ask what that plan is.)*

3. **PFC Jones states that she intend to take an overdose of pills and then shoot herself in the head with her rifle. How do you respond?** *(Indicate that suicide is a long-term solution to a short-term problem. Demonstrate caring by confiscating PFC Jones' medications and weapons. Then escort her to the emergency room for treatment of her cuts and bruises. Tell the staff in the emergency room that you feel PFC Jones is suicidal. While PFC Jones is being treated, call, and inform your chain-of-command of that night's events and your actions."*

4. **The treating physician comes out to you and states "PFC Jones is definitely suicidal and she has eloped from the emergency room." What do you do? (***Ask the physician if he/she has dialed Dial 911 and/or contacted the MP's. Report PFC Jones' plans and elopement to your chain-of-command.)*

5. **PFC Jones is found and admitted to the psychiatric ward. Can you help her even while she is hospitalized? If so, how?** *(One can visit her while she is hospitalized and assure her that the other members of the unit are awaiting her return. Hopefully, you will be able to tell her that SPC Smith is being punished for her actions and that she may be discharged from the army. Make sure that she knows that there is no reason to be embarrassed and that the other team members are looking forward to her return to duty. One can also inquire if there is anything PFC Jones needs to have done while she is hospitalized and offer to take care of these things for her.)*